State of New Jersey
Division of Workers' Compensation
Office of Special Compensation Funds

DECISION OF ELIGIBILITY

- Second Injury Fund Application –
SCF-6 (R 09-04)

01. Petitioner Social Security Number:	06. Petitioner Attorney FEIN:
02. Petitioner Name: / 03. Age:	07. Petitioner Attorney:
04. Petitioner Address:	08. Petitioner Attorney Address:
05. DAG Appearing For Second Injury Fund:	09. Appearing For Petitioner:

10. Fund Application Filed (date):	13. Vicinage:
11. Claim Petition Number:	14. Date of Hearing:
12. Consolidated With:	Judge of Compensation:

Upon the proofs presented and the stipulations made, I find and determine the following facts:

LAST COMPENSABLE ACCIDENT OR EXPOSURE

16. Claim Petition Number:	16. Claim Petition Number:
17. Date of Accident/Exposure:	20. Employer Address:
18. Weekly Gross Wages:	

21. Temporary Disability Award:

22. Permanent Disability Award:

23. Date of Totality:	24. Date of Last Payment of Compensation:

25. Description of Injury and Disability:

PRE-EXISTING COMPENSABLE DISABILITIES

1.	a. Date of Injury:	b. Claim Petition Number:
	c. Employer Name and Address	
	d. Temporary Disability Award:	
	e. Permanent Disability Award:	
	f. Description of Injury and Disability:	
	g. Hearing Date:	h. Hearing Office:

2.	a. Date of Injury:	b. Claim Petition Number:
	c. Employer Name and Address	
	d. Temporary Disability Award:	
	e. Permanent Disability Award:	
	f. Description of Injury and Disability:	
	g. Hearing Date:	h. Hearing Office:

3.	a. Date of Injury:	b. Claim Petition Number:
	c. Employer Name and Address	
	d. Temporary Disability Award:	
	e. Permanent Disability Award:	
	f. Description of Injury and Disability:	
	g. Hearing Date:	h. Hearing Office:

(Provide like data on additional sheets as required.)

PRE-EXISTING NON-COMPENSABLE DISABILITIES

1.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

2.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

3.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

4.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

5.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

6.	a. Date of Onset:	b. Origin (if known): ☐ Congenital ☐ Accident/Injury
	c. Description:	

(Provide like data on additional sheets as required.

PETITIONER PERSONAL DATA

01. Date of Birth:	02. Gender: ☐ Male ☐ Female

03. Date of Last Employment:	04. Occupation:	05. Gross Weekly Wages:
06. Employer Name and Address:		

07. Education (check one):	08. Special Occupational Skills:
☐ Some Grade/Junior High School ☐ Completed Junior High School ☐ Some High School ☐ Completed High School ☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐ Some Graduate School ☐ Graduate Degree	

09. Rehabilitation Potential:

10. Social Security Benefit Status:

Date Benefits Commenced: _____ Current Monthly Rate $_____ Reverse Offset? ☐ Yes ☐ No

(If reverse offset taken under N.J.S.A. 34:15-95.5, attach completed Form SCF-16)
(The Second Injury Fund reserves the right to offsets prescribed at N.J.S.A. 34:15-95.5 where Social Security Is payable to Petitioner. Petitioner shall promptly notify the Fund when such benefits are awarded.)

11. Third Party Actions:

If third party liability action is pending, provide the name and address of the attorney representing this petitioner if different than the workers' compensation attorney:

_____

_____

_____

(Respondent and Second Injury Fund reserve their rights under N.J.S.A. 34:15-40.)

12. Remarks:

DECISION

In accordance with the provisions of the New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.), I find as follows:

1. Petitioner is totally and permanently disabled.

2. The total and permanent disability is not due solely to the petitioner's last compensable accident or occupational exposure, but is due to the combined effects of the petitioner's previous disabilities and the last compensable accident or occupational exposure and is clearly within the provisions of the above cited statute.

3. Accordingly, it is determined that the petitioner receive benefits from the Second Injury Fund as follows:

   a. _____ weeks, being the difference between 450 weeks and the _____ weeks of permanent disability compensation previously received.

   b. Awarded base weekly rate is $_____.

   c. Payable base weekly rate is $ _____. (If third party or other credits are involved, please explain below.)

   d. Payment to begin upon the expiration of payment of compensation from the last compensation award, but, in any event, not sooner than the date of filing of the petition for benefits from the Second Injury Fund.

      Commencement date for Fund benefits is _____.

   e. Upon the expiration of the 450-week period, benefits to continue in accordance with the provision of N.J.S.A. 34:15-12(b) as amended.

_____

J*udge of Compensation*

_____

D*ate*

Explanation of #3.c., above, if required.